State of California - Health and Human Services Agency **Department of Health Care Services**

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

Ventura County Health Care Agency
Annual Report, PY 3 Rev. 3
May 17, 2019

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	☐ Completed Narrative report ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.) **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

Key accomplishments for PY 3 include:

- Recruited, hired, and trained and supported 13 additional staff (Medical Director, QI Coordinators, Database Analyst, CHW/CSWs and BH Clinicians) with >93% of CHW/CSW staff completing training in priority topics.
- Continued intensive enrollment of patients engaging 3,243 individuals through mobile outreach and enrolling 589 new unduplicated participants by year end.
- Ongoing implementation of expansion application activities including Care Pods (103 events with 2,271 individuals served) and Recuperative Care (1,908 bed days of recuperative care provided by year end).
- Aided in Wooley fire disaster response efforts enrolling WPC patients from Red Cross and Winter Warming Shelters.
- Supported Temporary Emergency Shelter/Navigation Center planning/launch efforts including bi-monthly interagency planning meetings, selection committee for shelter operator, operations and service planning for shelter.

Increasing integration among county agencies, health plans, providers, and other entities

Regular Leadership and Clinical Care meetings with the COHS, Gold Coast Health Plan (GCHP) resulted in sharing of data, shared learnings, and alignment of care coordination with the health plan. Provider and partner outreach through stakeholder presentations helped to promote the program and build a referral base for program enrollment.

Increasing coordination and appropriate access to care

Worked with internal and external stakeholders on understanding requirements of SB 1152 homeless discharge legislation, including shelter, area hospital and emergency room case managers. Discussed WPC and recuperative care as resources to aid in safe, timely, and appropriate discharges for homeless individuals. Worked with forms committee to include WPC referral in homeless discharge workflow for individuals meeting WPC criteria.

Reducing inappropriate emergency and inpatient utilization
Data on ED and IP utilization collected and analyzed in collaboration with GCHP through 2 quarterly PDSA cycles. Weekly case review initiated with Care Coordination Team members and newly hired WPC Medical director focusing on new, priority/urgent cases as well as all ER and hospital admits/discharges for the prior week.

Improving data collection and sharing
Selected IT platform vendor for data warehouse, health registry, and care coordination platform to be implemented in PY 4, Q2. Worked with Hospital Association of Southern California to engage area hospitals around shared ER data through Collective Medical Technologies EDIE software incentivized with WPC funds.

Achieving quality and administrative improvement benchmarks
Reviewed Data and Information Sharing and Care Coordination Policies and Procedures to guide these critical aspects of program implementation through 4 successive PDSA cycles. Completed quarterly PDSA cycles on 5 required and 1 optional (Q1) and 5 required and 2 optional (Qs2-4) quality and administrative benchmarks.

Increasing access to housing and supportive services
Coordinated with Human Services Agency and Continuum of Care to use Homeless Management Information System to access housing through County Coordinated Entry System. Provided 352 housing services to WPC-enrolled patients. Co-wrote, with Continuum of Care, successful application to Corporation for Supportive Housing/Social Finance Fund to complete study of costs among highest utilizing individuals across multiple systems.

Improving health outcomes for the WPC population
Reported health outcomes across more than ten utilization, health status, and access to service metrics, demonstrating positive results.

Challenges: Gaps in staffing during an Agency-wide hiring freeze, impacted case loads and ramp-up during early PY 3. This resolved in the second half of PY 3 requiring intensive training and support of new staff.

Lessons Learned: Medical case review with the new WPC Medical Director contributed to the team's ability to follow-up timely and appropriately on ED visits and Inpatient Hospitalizations contributing to continued reductions against baseline for these metrics.

III. ENROLLMENT AND UTILIZATION DATA

For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	94	62	87	64	36	31	374

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	48	43	29	48	30	17	589

For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	$ 17,080.80	$ 20,962.80	$ 28,079.80	$ 27,174.00	$ 31,961.80	$ 26,138.80	$ 151,398.00
Utilization 1	132	162	217	210	247	202	1,170
Service 2	$ 44,938.04	$ 38,856.20	$ 52,540.34	$ 40,545.60	$ 35,815.28	$ 44,600.16	$ 257,295.62
Utilization 2	266	230	311	240	212	264	1,523

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Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	$ 26,397.60	$ 17,339.60	$ 5,952.40	$ 27,044.60	$ 12,034.20	$ 6,728.80	$ 95,497.20
Utilization 1	204	134	46	209	93	52	738
Service 2	$ 48,147.90	$ 50,682.00	$ 54,567.62	$ 66,731.30	$ 36,828.92	$ 33,619.06	$ 290,576.80
Utilization 2	285	300	323	395	218	199	1720

For ***Per Member Per Month (PMPM),*** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$318.21	$ 29,911.74	$ 20,047.23	$ 27,684.27	$ 21,320.07	$ 11,455.56	$ 10,182.72	$ 120,601.59
MM Counts 1		94	63	87	67	36	32	379
Bundle #2	$269.69	$ 35,565.67	$ 43,959.47	$ 48,544.20	$ 55,556.14	$ 56,634.90	$ 58,253.04	$ 301513.42
MM Counts 2		143	163	180	206	210	216	1,118
Bundle #3	$223.74	$ 120,595.86	$ 131,335.38	$ 150,800.76	$ 161,540.28	$ 166,015.08	$ 168,476.22	$ 898,763.58
MM Counts 3		539	587	674	722	742	753	4,017

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Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$318.21	$13,683.03	$ 14,955.87	$ 10,819.14	$ 23,229.33	$ 18,456.18	$ 17,183.34	$ 98,326.89
MM Counts 1		43	47	35	73	58	54	310
Bundle #2	$269.69	$ 60,949.94	$ 62,837.77	$ 66,343.74	$ 69,040.64	$ 69,580.02	$ 70,928.47	$ 399,680.58
MM Counts 2		226	233	246	256	258	263	1,482
Bundle #3	$223.74	$ 178,097.04	$ 186,822.90	$ 193,982.58	$ 202,708.44	$ 203,155.92	$ 203,827.14	$ 1,168,594.02
MM Counts 3		796	835	867	906	908	911	5,223

Please provide additional detail, if any, about your enrollment and utilization for this reporting period. (Optional)

The MidYear invoice was submitted before final draft of the PY 3 Q2 Enrollment Report was submitted. The MidYear invoice total for PMPM has been updated to align with the final PY 3 Q2 Quarterly Enrollment Report.

IV. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report.

In PY 3, the Ventura County Whole Person Pilot continued staffing up to serve an expanding participant population, filling the following positions under Administrative Infrastructure:

- Medical Director – (part time) medical supervision of WPC operations, week chart reviews and case conferences for new and high-risk patients, patients in the ER or hospital.
- QI Coordinator – two staff to support ongoing QI efforts including refinement of referral workflows, documentation audits, care plan completion audits
- Database analyst – one full-time staff to manage the WPC enrollment database, export data for QI processes and quarterly enrollment reports, prepare data for transfer into registry and care coordination platform.

The Informaticist position continues to be filled by internal resources on a part-time, as needed basis.

As discussed in the PY 3 to 4 rollover request, the BH Director will remain unfilled with funds rolling over into other line items due to difficulties filling open psychiatry positions within the County. The WPC Financial Manager will remain unfilled with funds rolling over into other line items with these duties provided by in-house resources on an in-kind basis.

Legal counsel reviewed other county Universal Consent forms and suggested a format to be used locally.

The pilot spent $7,500 on laptop computers, desktop monitors, and $34.87 on cell phones for new CHWs/CSWs and BH Clinicians hired under the PMPM bundles.

Indirect amount reported of $496,614.86 is based on 5% of direct costs totaling $9,932,297.17.

V. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

IT Development and Centralized Enterprise Infrastructure expenditures supported the ongoing development of the data warehouse integral to WPC data exports for the Universal and Variant Metrics calculations. The data warehouse also supports the integration of data from multiple other sources. This work will continue through April 2019, at which point the Cerner HealthE Intent data warehouse will come online as envisioned in the PY 3 to 4 rollover request.

PY 3 funds remaining for Central Enterprise Infrastructure, WPC Connect Contract, and Health Registry Contract will be rolled into PY 4 as described in the PY 3 to 4 rollover request and will fund the launch of Cerner EHR-compatible data warehouse engine, registry, and care coordination products in support of WPC efforts. The Ventura WPC pilot previewed multiple state of the art IT platforms across PY 2 and PY 3 but ultimately selected products within the Cerner suite for ease of launch and ongoing compatibility/functionality.

The i2i registry was launched in PY 3 but will be transferred to a Cerner-compatible project in PY 4 for expanded functionality.

EpiCenter and Tiger Text Secure Text Messaging were implemented in PY 3 as approved in the PY 3 budget adjustment request.

Care Pod operating costs of $88,002.61 were expended in support of weekly Care Pod events at two sites, River Haven and El Buen Pastor.

VI. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

The following incentive payments were earned in the second half of PY3 and claimed on the invoice:

352 housing services were completed by WPC team members in alignment with those services described in the approved WPC application for a total of $52,800 claimed, payable to the Lead Entity.

185 of 189 patients (or 93%) had a care plan within 30 days of enrollment for a total of $92,500 claimed, payable to the lead entity.

The incentive for care plan update within 30 days of anniversary was not met. This is critical to the success of WPC efforts and, through a PDSA effort, is being monitored daily through the huddle and huddle notes in PY 4.

350 ED visits for mental health were followed up within 30 days by a licensed provider at a rate of 70.2% for a total of $154,000 claimed payable to the lead entity.

13 stakeholder meeting attendance fees were payed to stakeholders at the El Buen Pastor Care Pod site for monthly operations meetings totaling $1,300.

57 Care Pod Community Service Events were held for a total of $570,000.

9 WPC-enrolled patients received HSA services and housing supports via the HDAP program for a payment of $80,000.

CHWs/CSWs were trained in the following:

- 5As, 11/1/18, 80% completion rate - $100,000
- SBIRT, 11/29/18, 90% completion rate -- $100,000
- Self-Management Goals, 9/13/18, 90% completion rate -- $100,000

49.1% increase in WPC enrollees screened for substance abuse and mental health using SBIRT (min. 3%) for a total of $205,300. 86% of new WPC enrollees from 7/1/18-12/31/18 had a completed care plan with self-management goals within 30 days of enrollment for a total of $189,500.

VII. NARRATIVE – Pay for Outcome

Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology.

The Annual Report and WPC Universal and Variant Metrics Reporting Template submitted with the Annual Report, included metrics for the following pay-for-outcome measures:

- Ambulatory Care Emergency Department (AMB/ED) – 308.1 Ambulatory Care ED Visits per 1,000 Member Months, 26% reduction from baseline, Attained through 20% tier.
- Inpatient Utilization (IPU) – 55.5 Inpatient Discharges per 1,000 Member Months, 27% decrease from baseline, Attained.
- All Cause Readmissions – 25.5%, 42% reduction from baseline, Attained.
- Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET) – 54% Initiation within 14 Days of Diagnosis, 32% within 30 days of Diagnosis, 42% and 88% improvement respectively over baseline, Attained.
- Comprehensive Diabetes Care (CDC-H8) – 52.4%, 3.2% improvement, Partial Payment, Tiered Metric.
- Depression Remission - 5% Attained.
- Major Depressive Disorder – 7.28%, Attained
- Housing Services – 72.5%, 199% improvement over baseline, Attained.
- Follow-Up After Hospitalization for Mental Health (FUH) – 63.8% within 7 days of discharge, 85.1% within 30 days of discharge, 47% and 28% improvements respectively. Attained.
- Comprehensive Care Plan, 93% New, 25% Annual
- Optional Variant Metric: CHW Training (M1), 93.8%, Attained
- Optional Variant Metric: CSW Encounters (M6), 39% Did not Meet.
- Optional Variant Metric: Recuperative Care Readmissions within 90 Days of Discharge, 61.1% not admitted within 90 days of discharge against 55% target, Attained.

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

See attached program policy meetings held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings.

IX. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.

(1) Cohosted with HASC, information event for hospital and ER case managers for area hospitals on new legislation pertaining to discharge of homeless persons (SB 1152). Presented role for WPC pilot and recuperative care in aiding safe/timely/compliant discharges. Integrated WPC referral into VCMC hospital discharge workflow.

(2) Developed standardized disenrollment procedures for scenarios such as lack of engagement, incarceration, SNF placement, beneficiary request and staff workflows.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.

(1) The metric for 6 CSW visits was not met. This was due to concentration of services around high need individuals, staffing gaps during hiring freeze/training of new staff, lack of continuous engagement in the context of high caseloads, documentation challenges.

(2) This will be addressed through a PDSA cycle in PY 4 with attention to balancing caseloads, staff training, documentation audits/support, and workflows for continuous engagement.

c.) Briefly describe 1-2 successes you have had with data and information sharing.

(1) Collaboration with HASC to incentivize Collective Medical Technologies/EDIE implementation across area hospitals where 65% of WPC ED visits and 50% of WPC hospitalizations take place. Will enable real time alerts for ED and hospital events and sharing of patient information and care plans across hospitals and should aid in timely follow-up with WPC-assigned patients.

d.) Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.

(1) Data sharing with MediCal contracted mental health provider for mild-to-moderate behavioral health concerns has been problematic, with information about status of referrals going back only to referring party, clinicians reluctant to share client information with WPC clinicians or requiring a signed release. Issue determined to be that LPS data sharing does not flow down to contracted private providers.

(2) Through Care Coordination workgroup with GCHP, working to address issue with GCHP and Beacon contracted provider.

e.) Briefly describe 1-2 successes you have had with data collection and/or reporting.

(1) With hiring of database analyst and QI coordinator, enrollment documentation, quarterly enrolment reports, and data exports for QI processes have been more timely, efficient, accurate.

(2) Data requirements for metrics reporting have been regularized between data partners, GCHP and Ventura County Behavioral Health making with mid-year and annual reports a faster, more efficient process.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

(1) Work flows and data elements need to be better mapped for PHQ-9 and suicide risk assessment. Much of the effort we put into PHQ-9 implementation didn't fit within metric time frames or required chart review to complete the metric. This will be addressed through a debrief after completion of the annual report.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?

Sustainability – Just as WPC processes and learnings are becoming established; the program is scheduled to end potentially limiting some of the impacts of Whole Person Care. PY 4 and 5 efforts will focus on key areas of sustainability such as the technology infrastructure and identifying potential sustainable funding sources for some aspects of Whole Person Care.

Recent legal challenges to the Affordable Care Act could have an impact on Medicaid Expansion and adult expansion population served under Whole Person Care.

X. PLAN-DO-STUDY-ACT

PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

List PDSA attachments

- Reducing ED utilization, Qs 1-4
- Reducing avoidable inpatient utilization and readmissions, Qs 1-4
- Ensuring comprehensive care plan development, Qs 1-4
- Care coordination, case management, and referral policies and procedures development, Qs 1-4
- Data and information sharing policies and procedures development, Qs 1-4
- CHW training, Qs 1-4
- Optional - WPC target population enrollment, Qs 3 and 4